		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040543

Facility Name: Tabor Hills Health Care Facility

Address: 1347 Crystal Court (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

Telephone Number: (630) 778-6677 **Fax #** (630) 778-6680

IDPA ID Number: 363867476001

Date of Initial License for Current Owners: 04/28/95

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501 (c) (3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Mr. Charles Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2003 to 09/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,424	1
2		Skilled Pediatric (SNF/PED)			2
3	147	Intermediate (ICF)	147	53,802	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,226	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,109	2,742	6,370	10,221	8
9	SNF/PED					9
10	ICF	24,377	35,798		60,175	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,486	38,540	6,370	70,396	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.16%

D. How many bed-hold days during this year were paid by Public Aid?
3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/28/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/28/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 6,305

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/2004 Fiscal Year: 09/30/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	381,319	34,757	8,113	424,189		424,189		424,189			1
2	Food Purchase		332,264		332,264		332,264		332,264			2
3	Housekeeping	293,784	65,920	29,340	389,044		389,044		389,044			3
4	Laundry	125,296	32,427	977	158,700		158,700		158,700			4
5	Heat and Other Utilities			215,578	215,578		215,578		215,578			5
6	Maintenance	191,449	62,249	183,826	437,524		437,524		437,524			6
7	Other (specify):*											7
8	**TOTAL General Services**	991,848	527,617	437,834	1,957,299		1,957,299		1,957,299			8
	B. Health Care and Programs											
9	Medical Director			25,785	25,785		25,785		25,785			9
10	Nursing and Medical Records	4,114,694	342,898	1,014,103	5,471,695		5,471,695		5,471,695			10
10a	Therapy	264,165	59,595	75,439	399,199		399,199		399,199			10a
11	Activities	128,189	3,257	5,133	136,579		136,579		136,579			11
12	Social Services	90,285	791	4,043	95,119		95,119		95,119			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,597,333	406,541	1,124,503	6,128,377		6,128,377		6,128,377			16
	C. General Administration											
17	Administrative	157,489			157,489		157,489		157,489			17
18	Directors Fees											18
19	Professional Services			172,148	172,148		172,148	(25,522)	146,626			19
20	Dues, Fees, Subscriptions & Promotions			58,487	58,487		58,487		58,487			20
21	Clerical & General Office Expenses	375,195	57,342	44,964	477,501		477,501	(644)	476,857			21
22	Employee Benefits & Payroll Taxes			1,496,582	1,496,582		1,496,582		1,496,582			22
23	Inservice Training & Education			500	500		500		500			23
24	Travel and Seminar			11,599	11,599		11,599		11,599			24
25	Other Admin. Staff Transportation			8,947	8,947		8,947		8,947			25
26	Insurance-Prop.Liab.Malpractice			570,572	570,572		570,572		570,572			26
27	Other (specify):*											27
28	**TOTAL General Administration**	532,684	57,342	2,363,799	2,953,825		2,953,825	(26,166)	2,927,659			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,121,865	991,500	3,926,136	11,039,501		11,039,501	(26,166)	11,013,335			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tabor Hills Health Care Facility #0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			511,757	511,757		511,757	(12,997)	498,760			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			469,420	469,420		469,420	(18)	469,402			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			981,177	981,177		981,177	(13,015)	968,162			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		200,170		200,170		200,170		200,170			39
40	Barber and Beauty Shops			31,875	31,875		31,875		31,875			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,840	115,840		115,840		115,840			42
43	Other (specify):* Nonallowable Costs			76,822	76,822		76,822	(76,822)				43
44	**TOTAL Special Cost Centers**		200,170	224,537	424,707		424,707	(76,822)	347,885			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,121,865	1,191,670	5,131,850	12,445,385		12,445,385	(116,003)	12,329,382			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,997)	30		9
10	Interest and Other Investment Income	(18)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,666)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(88,322)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,003)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (116,003)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility
Provider #: 0040543
10/01/2003 to 09/30/2004 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Disallow resident physicians	(7,530.00)	43
Disallow miscellaneous expense	(11,385.00)	43
Disallow X-Ray expense	(14,872.00)	43
Disallow Lab expense	(24,008.00)	43
Disallow Clothing expense	(165.00)	43
Miscellaneous income offset	(644.00)	21
Disallow out of period legal fees	(25,522.00)	19
Disallow resident funeral expense	(981.00)	43
Disallow residents transportation	(164.00)	43
Disallow residents insurance	(1,812.00)	43
Disallow Travel & Entertainment	(1,239.00)	43
Total	(88,322.00)	

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility

ID# 0040543

Report Period Beginning: 10/01/2003

Ending: 09/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tabor Hills Health Care Facility **#** 0040543 **Report Period Beginning:** 10/01/2003 **Ending:** 09/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 **Report Period Beginning:** 10/01/2003 **Ending:** 09/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(12,997)	0	0	0	0	0	0	0	0	0	0	(12,997)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18)	0	0	0	0	0	0	0	0	0	0	(18)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,015)	0	0	0	0	0	0	0	0	0	0	(13,015)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(14,666)	0	0	0	0	0	0	0	0	0	0	(14,666)	43
44	**TOTAL Special Cost Centers**	(14,666)	0	0	0	0	0	0	0	0	0	0	(14,666)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,681)	0	0	0	0	0	0	0	0	0	0	(27,681)	45

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bohemian Home for the Aged	100%			Bohemian Home for the Aged	Naperville	Townhomes
See attached schedule 6A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V				N/A				7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility
Provider #: 0040543
10/01/2003 to 09/30/2004

Schedule 6A

Officers/ Board of Directors

President
Stanley D. Loula
The Law Centre
5814 West Cermak Road
Cicero, IL. 60804

Vice President
Walter Wlodek
The Law Centre
5814 West Cermak Road
Cicero, IL. 60804
(708) 656-0600

Secretary
Gloria J. Pindiak
1347 Crystal Ave.
Naperville, IL. 60563

Treasurer
Charles Capek
1432 Crystal Ave
Naperville, IL. 60563

* See Accountants Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5					N/A					5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Northwest Bank of Wisconsin		X	Mortgage	Principal and	03/31/98	$ 8,095,000	$ 7,285,950	11/2024	varies	$ 449,195	1
2					Interest due							2
3					Semi-annually							3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 8,095,000	$ 7,285,950			$ 449,195	9
	B. Non-Facility Related*											
10												10
11												11
12							Interest Income Offset				(18)	12
13							Amortization of Loan Fees				20,225	13
14	TOTAL Non-Facility Related						$	$			$ 20,207	14
15	TOTALS (line 9+line14)						$ 8,095,000	$ 7,285,950			$ 469,402	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tabor Hills Health Care Facility COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0040543

CONTACT PERSON REGARDING THIS REPORT Ms. Gloria Pindiak

TELEPHONE (630) 778-6677 FAX #: (630) 778-6680

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.		N/A	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,980 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Bohemian Home for the Aged d/b/a Tabor Hills Adult Community provides housing to seniors through an adult living community.
There are 104 townhomes and a total of 1,267,596 square feet of land.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	264,519	1995	$ 574,693	1
2					2
3	TOTALS	264,519		$ 574,693	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1995	1995	$ 10,039,753	$ 249,932	40	$ 250,994	$ 1,062	$ 2,383,906	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land improvements			1995	36,958	2,751	15	2,464	(287)	23,407	9
10	Improvements			1995	1,421		40	36	36	471	10
11	Sign			1997	500	13	40	13		97	11
12	Electric			1996	656	16	40	16		120	12
13	Humidistats			1996	1,378	34	40	34		255	13
14	Door alarm			1996	854	22	40	22		165	14
15	Plumbing			1996	1,050	26	40	26		195	15
16	Install lights, water heater			1997	2,345	58	40	58		435	16
17	Pipe			1997	618	16	40	16		120	17
18	Electric			1997	3,121	78	40	78		585	18
19	Signs & outlets			1997	2,504	62	40	62		465	19
20	Wall hugging overbed lights			1997	27,302	671	40	671		5,050	20
21	Air compressor			1997	2,078	52	40	52		390	21
22	Roof repair			1997	3,154	78	40	78		585	22
23	Deco-gard products			1997	738	18	40	18		136	23
24	Shelving units			1998	2,317	58	40	58		377	24
25	Chimney cap			1998	945	95	40	24	(71)	156	25
26	Access door			1998	2,061	52	40	52		338	26
27	Bumper guards			1998	3,687	92	40	92		598	27
28	Land improvement - survey			1998	800		10	80	80	520	28
29	Carpeting			1999	67,303	6,730	10	6,730		36,455	29
30	Miniblinds			1999	3,501	350	10	350		1,779	30
31	Vertical blinds			1999	1,974	197	10	197		1,150	31
32	Swingmaster door			1999	2,357	236	10	236		1,376	32
33	Security lock			1999	2,779	278	10	278		1,552	33
34	WanderGuard code alert system			1999	16,182		10	1,618	1,618	8,899	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2000	$ 225	$ 22	10	$ 22	$	$ 91	37
38	Railing & Bumper	2000	3,275	81	40	81		371	38
39	Carpeting	2000	41,999	4,200	10	4,200		16,450	39
40	Tile	2001	6,493	162	40	162		622	40
41	Courtyard improvements	2001	15,673	391	40	391		1,207	41
42	Architect Fees-Dining room	2002	58,322	5,832	10	5,832		5,832	42
43	Carpet	2002	3,341	334	10	334		668	43
44	Door Alarm	2003	8,254	825	10	825		1,306	44
45	Fountain	2003	2,278	228	10	228		323	45
46	Carpet	2003	4,545	455	10	455		455	46
47	Therapeutic Garden	2003	135,525	1,926	40	1,926		1,926	47
48	Windows	2003	600	15	40	15		15	48
49	Braille Room Signs	2003	3,156	40	40	40		40	49
50	Flooring & Ceiling Tile	2004	12,755	160	40	160		160	50
51	Architect Fees-Dining room	2004	17,405	218	40	218		218	51
52	Air Conditioning	2004	32,155	1,608	10	1,608		1,608	52
53	Plumbing	2004	30,619	466	40	466		466	53
54	Doors	2004	12,160	608	10	608		608	54
55	Water Box	2004	1,996	100	10	100		100	55
56	Fire Alarm	2004	8,965	448	10	448		448	56
57	Driveway	2004	2,750	138	10	138		138	57
58	Electric Work & Lighting	2004	213,367	536	40	536		551	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,844,194	$ 280,708		$ 283,146	$ 2,438	$ 2,503,185	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,874,441	$ 199,947	$ 184,512	$ (15,435)	5-10 years	$ 1,506,254	71
72	Current Year Purchases	307,513	16,335	16,335		5-10 years	16,335	72
73	Fully Depreciated Assets	136,558					136,558	73
74								74
75	TOTALS	$ 2,318,512	$ 216,282	$ 200,847	$ (15,435)		$ 1,659,147	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Schedule 13A			$ 141,338	$ 14,767	$ 14,767	$	5	$ 108,211	76
77										77
78										78
79										79
80	TOTALS			$ 141,338	$ 14,767	$ 14,767	$		$ 108,211	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,878,737	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 511,757	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 498,760	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,997)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,270,543	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-care related Bus	$ 38,750	$	$ 38,750	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 38,750	$	$ 38,750	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 1,556,703	92
93			93
94			94
95		$ 1,556,703	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
10.01.03 to 9.30.04

Schedule 13A

Schedule XI - D Vehicle Depreciation

Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustment	Life in Years	Accumulated Depreciation
Facility Use	1997 Ford Eldorado Bus	1997	44,290.00			-	5	44,290.00
Medical Transportatior	1988 Ford Van	1988	23,216.00			-	5	23,216.00
Facility Use	2000 Chrysler Van	2000	31,930.00	6,386.00	6,386.00	-	5	28,833.00
Administrative Use	2003 Van	2003	41,902.00	8,381.00	8,381.00	-	5	11,872.00
			141,338.00	14,767.00	14,767.00	-		108,211.00

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A,C1 &C3	2075 hrs	$ 66,399	43	$ 1,719	$	2,118	$ 68,118	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,727	31,088		1,727	31,088	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C1, C2	3457 hrs	145,184	948	23,699	31,167	4,405	200,050	4
5	Physician Care	& C3	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				200,170		200,170	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Sch. 16A				540	18,933	28,428	540	47,361	13
14	TOTAL			$ 211,583	3,258	$ 75,439	$ 259,765	8,790	$ 546,787	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility
Provider #: 0040543
10/01/2003 to 09/30/2004

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
Respiratory Therapy	L10A, C3	540	18,933	
Oxygen	L10A, C2			28,428
	Total		18,933	28,428

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,273	$ 27,273	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 61,124)	977,029	977,029	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	330,943	330,943	6
7	Other Prepaid Expenses	20,609	20,609	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,355,854	$ 1,355,854	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	574,693	574,693	13
14	Buildings, at Historical Cost	9,997,265	10,039,754	14
15	Leasehold Improvements, at Historical Cost	787,562	804,440	15
16	Equipment, at Historical Cost	2,529,287	2,459,850	16
17	Accumulated Depreciation (book methods)	(4,348,486)	(4,270,543)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp see Sch 17A	1,778,096	1,778,096	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,318,417	$ 11,386,290	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,674,271	$ 12,742,144	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 803,464	$ 803,464	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	190,350	190,350	29
30	Accrued Salaries Payable	432,366	432,366	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	209,080	209,080	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	99,410	99,410	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,734,670	$ 1,734,670	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,095,600	7,095,600	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,095,600	$ 7,095,600	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,830,270	$ 8,830,270	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,844,001	$ 3,911,874	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,674,271	$ 12,742,144	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
10.01.03 to 9.30.04

Schedule 17A

XV. Balance Sheet

B. Long Term Assets - Line 22

	Operating	After Consolidation
Finance Fees	$ 211,393.00	$ 211,393.00
Construction in Progress	$ 1,566,703.00	$ 1,566,703.00
Total	**$ 1,778,096.00**	**$ 1,778,096.00**

C. Current Liabilities - Line 36

	Operating	After Consolidation
Resident Credit Balances	$ (55,745.00)	$ (55,745.00)
Accrued Wage Assignment	$ (651.00)	$ (651.00)
Other Liabilities	$ (43,014.00)	$ (43,014.00)
Total	**$ (99,410.00)**	**$ (99,410.00)**

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,134,976	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,134,976	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(907,932)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (907,932)	17
	B. Transfers (Itemize):		
18	**Interorganization Transfers**	2,616,957	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,616,957	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,844,001	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,975,136	1
2	Discounts and Allowances for all Levels	(1,017,727)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,957,409	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	716,146	6
7	Oxygen	18,915	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 735,061	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	31,650	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	765	15
16	Rental of Facility Space		16
17	Sale of Drugs	235,118	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,687	19
20	Radiology and X-Ray	13,519	20
21	Other Medical Services	483,073	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 786,812	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	58,153	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 58,153	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,537,453	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,957,299	31
32	Health Care	6,128,377	32
33	General Administration	2,953,825	33
	B. Capital Expense		
34	Ownership	981,177	34
	C. Ancillary Expense		
35	Special Cost Centers	308,867	35
36	Provider Participation Fee	115,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,445,385	40
41	**Income before Income Taxes (line 30 minus line 40)****	(907,932)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (907,932)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
10.01.03 to 9.30.04

Schedule 19A

XV. Income Statement

E. Other Revenue - Line 28

	Amount
Bedhold Income	$51,858
Misc. Income	$644
Resident Misc. Income	$5,651
Total	$58,153

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,939	2,091	$ 70,122	$ 33.54	1
2	Assistant Director of Nursing	1,853	2,091	61,223	29.28	2
3	Registered Nurses	50,067	53,477	1,245,095	23.28	3
4	Licensed Practical Nurses	17,951	19,343	353,497	18.28	4
5	Nurse Aides & Orderlies	126,727	136,072	1,701,729	12.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,881	7,471	211,583	28.32	7
8	Rehab/Therapy Aides	10,607	11,725	134,413	11.46	8
9	Activity Director	1,983	2,206	29,629	13.43	9
10	Activity Assistants	9,819	10,842	98,560	9.09	10
11	Social Service Workers	7,117	7,781	90,285	11.60	11
12	Dietician					12
13	Food Service Supervisor	1,932	2,139	42,891	20.05	13
14	Head Cook	3,917	4,460	62,418	14.00	14
15	Cook Helpers/Assistants	26,198	27,466	242,604	8.83	15
16	Dishwashers	4,345	4,569	33,406	7.31	16
17	Maintenance Workers	13,068	13,748	191,449	13.93	17
18	Housekeepers	34,743	36,865	293,784	7.97	18
19	Laundry	13,089	13,704	125,296	9.14	19
20	Administrator	1,883	2,091	93,356	44.65	20
21	Assistant Administrator	1,933	2,091	64,133	30.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,161	24,351	375,195	15.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,010	6,720	85,908	12.78	31
32	Other Health Ca See Sch 20A	24,277	24,773	515,289	20.80	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	388,500	416,076	$ 6,121,865 *	$ 14.71	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,113	L1, C3	35
36	Medical Director	Monthly	25,785	L9, C3	36
37	Medical Records Consultant	71	2,112	L10, C3	37
38	Nurse Consultant	Monthly	9,136	L10, C3	38
39	Pharmacist Consultant	Monthly	6,488	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	122	2,448	L11, C3	44
45	Social Service Consultant	70	4,043	L12, C3	45
46	Other(specify) Medical Consultant	Monthly	2,400	L10, C3	46
47	Alzheimers Consultant	64	2,938	L10, C3	47
48	Management Consultant	Monthly	6,500	L10, C3	48
49	TOTAL (lines 35 - 48)	327	$ 69,963		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	15,095	$ 679,291	L10, C3	50
51	Licensed Practical Nurses	3,185	98,718	L10, C3	51
52	Nurse Aides	10,295	205,908	L10, C3	52
53	TOTAL (lines 50 - 52)	28,575	$ 983,917		53

Tabor Hills Health Care Facility, Inc.
IDPH Facility # 0040543
10.01.03 to 9.30.04
Schedule 20A

Page 20 - Schedule XVIII. A. Staffing and Salary Costs
Line 32 - Other

Description	Hours Worked	Hours Paid	Wages	Average Wages
Wound Care Coordinator	3,249	3,289	75,925.00	23.08
Ward Clerk	3,579	3,599	65,129.00	18.10
Care Plan Coordinator	4,431	4,687	118,402.00	25.26
Special Care Unit Manager	1,579	1,619	36,433.00	22.50
Restorative Services	6,634	6,674	108,445.00	16.25
Quality Assurance	3,105	3,155	58,373.00	18.50
Rehabilitation Nurses	1,700	1,750	52,582.00	30.05
Total	24,277.00	24,773.00	515,289.00	

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gloria Pindiak	Administrator	0	$ 93,356
Clara Leonard	Asst. Administrator	0	64,133
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 157,489

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule 21A		172,148
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 172,148

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 182,648
Unemployment Compensation Insurance	20,279
FICA Taxes	449,991
Employee Health Insurance	230,142
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	3,501
Employee Appreciation	16,125
401(k) Expense	19,617
Employee Pension	533,559
Life/Disability Insurance	32,675
Other Employee Benefits	8,045
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,496,582

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,220
Advertising: Employee Recruitment	31,908
Health Care Worker Background Check	
(Indicate # of checks performed 90)	1,832
Life Services Network of Illinois	11,493
License, Permits & Inspections	1,428
Subscriptions	2,423
Membership Dues	3,183
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 58,487

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,599
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,599

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility
Provider #0040543
10/01/03 to 09/30/04

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Duane Morris	Legal	55,059
Burke, Warren, MacKay & Serritella, P.C.	Legal	21,528
Erickson, Papanek, Hanson & Peterson	Legal	8,311
Intech Consultants, Inc.	Architect	1,106
Wessles & Pautsch	Legal	470
Hoeval & Associates	Legal	219
Dommermuth, Brestal, Cobine, and West, Ltd.	Legal	60
American Express Tax & Business Services	Tax & Accounting	3,591
Altschuler, Melvoin & Glasser LLP	Audit & Accounting	53,426
Ivans	Computer	1,305
HDSI	Computer	7,081
Vopenka & Associates	Computer	19,201
Other Various (non-legal)	Computer	792
Total (agree to Schedule V, line 19, column 3)		172,148
Non-allowable Legal Fees		(25,522)
Total (agree to Schedule V, line 19, column 8)		146,626

See Accountants' Compilation Report

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4								N/A					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 **Report Period Beginning:** 10/01/2003 **Ending:** 09/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois-$11,493**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **108,819** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **115,840**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	381,319	34,757	8,113	424,189	0	424,189	0	424,189
2. Food Purchase	0	332,264	0	332,264	0	332,264	0	332,264
3. Housekeeping	293,784	65,920	29,340	389,044	0	389,044	0	389,044
4. Laundry	125,296	32,427	977	158,700	0	158,700	0	158,700
5. Heat and Other Utilities	0	0	215,578	215,578	0	215,578	0	215,578
6. Maintenance	191,449	62,249	183,826	437,524	0	437,524	0	437,524
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	991,848	527,617	437,834	1,957,299	0	1,957,299	0	1,957,299
9. Medical Director	0	0	25,785	25,785	0	25,785	0	25,785
10. Nursing & Medical Records	4,114,694	342,898	1,014,103	5,471,695	0	5,471,695	0	5,471,695
10a. Therapy	264,165	59,595	75,439	399,199	0	399,199	0	399,199
11. Activities	128,189	3,257	5,133	136,579	0	136,579	0	136,579
12. Social Services	90,285	791	4,043	95,119	0	95,119	0	95,119
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,597,333	406,541	1,124,503	6,128,377	0	6,128,377	0	6,128,377
17. Administrative	157,489	0	0	157,489	0	157,489	0	157,489
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	172,148	172,148	0	172,148	-25,522	146,626
20. Fees, Subscriptions & Promotion	0	0	58,487	58,487	0	58,487	0	58,487
21. Clerical & General Office	375,195	57,342	44,964	477,501	0	477,501	-644	476,857
22. Employee Benefits & Payroll	0	0	1,496,582	1,496,582	0	1,496,582	0	1,496,582
23. Inservice Training & Education	0	0	500	500	0	500	0	500
24. Travel and Seminar	0	0	11,599	11,599	0	11,599	0	11,599
25. Other Admin. Staff Trans	0	0	8,947	8,947	0	8,947	0	8,947
26. Insurance-Prop.Liab.Malpractice	0	0	570,572	570,572	0	570,572	0	570,572
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	532,684	57,342	2,363,799	2,953,825	0	2,953,825	-26,166	2,927,659
29. Total General Administrative	6,121,865	991,500	3,926,136	11,039,501	0	11,039,501	-26,166	11,013,335
30. Depreciation	0	0	511,757	511,757	0	511,757	-12,997	498,760
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	469,420	469,420	0	469,420	-18	469,402
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	981,177	981,177	0	981,177	-13,015	968,162
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	200,170	0	200,170	0	200,170	0	200,170
40. Barber and Beauty Shop	0	0	31,875	31,875	0	31,875	0	31,875
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	115,840	115,840	0	115,840	0	115,840
43. Other (specify):*	0	0	76,822	76,822	0	76,822	-76,822	0
44. Total Special Cost Ce	0	200,170	224,537	424,707	0	424,707	-76,822	347,885
45. Grand Total	6,121,865	1,191,670	5,131,850	12,445,385	0	12,445,385	-116,003	12,329,382

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	27,273	27,273
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	977,029	977,029
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	330,943	330,943
7. Other Prepaid Expenses	20,609	20,609
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,355,854	1,355,854
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	574,693	574,693
14. Buildings, at Historical Cost	9,997,265	10,039,754
15. Leasehold Improvements, Historical Cost	787,562	804,440
16. Equipment, at Historical Cost	2,529,287	2,459,850
17. Accumulated Depreciation (book methods)	-4,348,486	-4,270,543
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	1,778,096	1,778,096
23. other (specify):	0	0
24. Total Long-Term Assets	########	11,386,290
25. Total Assets	########	12,742,144
CURRENT LIABILITIES		
26. Accounts Payable	803,464	803,464
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	190,350	190,350
30. Accrued Salaries Payable	432,366	432,366
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	209,080	209,080
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	99,410	99,410
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,734,670	1,734,670
LONG TERM LIABILITES		
39.Long-Term Notes Payable	7,095,600	7,095,600
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	7,095,600	7,095,600
46.Total Liabilities	8,830,270	8,830,270
47.Total Equity	3,844,001	3,911,874
48.Total Liabilities and Equity	########	12,742,144

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,975,136
2. Discounts and Allowances for all Levels	-1,017,727
Subtotal - Inpatient Care	9,957,409
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	716,146
7. Oxygen	18,915
Subtotal - Anciliary Revenue	735,061
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	31,650
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	765
16. Rental of Facility Space	0
17. Sale of Drugs	235,118
18. Sale of Supplies to Non-Patients	0
19. Laboratory	22,687
20. Radiologyand X-Ray	13,519
21. Other Medical Services	483,073
22. Laundry	0
Subtotal - Other Operating Revenue	786,812
24. Contributions	0
25. Interest and Other Investments Income	18
Subtotal - Non-Operating Revenue	18
27. Other Revenue (specify):	0
28. Other Revenue (specify):	58153
Subtotal - Other Revenue	58,153
30. Total Revenue	11,537,453
31. General Services	1,957,299
32. Health Care	6,128,377
33. General Administration	2,953,825
34. Ownership	981,177
35. Special Cost Centers	308,867
35. Provider Participation Fee	115,840
37. Other	0
40. Total Expenses	12,445,385
41. Income Before Income Taxes	-907,932
42. Income Taxes	0
43. Net Income or Loss for the Year	-907,932

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